State of California Department of Consumer Affairs

PHYSICIAN ASSISTANT COMMITTEE
MEDICAL BOARD OF CALIFORNIA
1424 Howe Avenue, Suite 35, Sacramento, CA 95825
Telephone: (916) 561-8780 FAX: (916) 263-2671
CALIFORNIA RELAY SERVICE BY TDD: 1-800-735-2929
E-mail: pacommittee@mbc.ca.gov

PHYSICIAN ASSISTANT TRAINING PROGRAM APPLICATION

FOR COMMITTEE USE ONLY
PGM _____
DATE APPROVED: _____

Please type or print clearly

PROGRAM NAME:			
MAILING ADDRESS:		*Number & Street*	
City	*State*	*Zip code*	*TELEPHONE: ( )* *FAX: ( )*
Email:			*Web Address:* *www.*

PROGRAM DIRECTOR:			
MEDICAL DIRECTOR:			
ASSOCIATED EDUCATIONAL INSTITUTION:			
MAILING ADDRESS:		*Number & Street*	
City	*State*	*Zip code*	*TELEPHONE: ( )* *FAX: ( )*

ACCREDITING AGENCY:		
CATEGORY OR LIMIT: *(full, provisional, etc.)*	*DATE OF ACCREDITATION:*	*EXPIRATION DATE:*

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PHYSICIAN ASSISTANT TRAINING PROGRAM
SELF-CERTIFICATION OF COMPLIANCE FOR A CALIFORNIA-APPROVED PROGRAM

I, _____, Program Director, of the
(printed name of program director)

_____,
(printed name of PA training program)

certify that this program meets the requirements to become a California-approved physician assistant training program as set forth in the California Code of Regulations, Title 16, Article 3, Sections 1399.530 to 1399.539.

I declare under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

_____ _____
(signature of program director) *(date)*

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REV 1/03

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